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# PAIN QUESTIONNAIRE

Please Circle the Number Below that Best Corresponds with Your Pain Level.
You May Circle One Number Below for Each of the Following: NOW / AT WORST / AT BEST (Please indicate)

| *No Pain* | | | | | | | | | *Worst Pain Possible* | |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please Indicate if the Following Activities Increase (↑), Decrease (↓), or do not Change (=) Your Pain:

Sitting: _____ Standing: _____ Walking: _____ Laying on Back: _____ Laying on Stomach: _____
Coughing: ______ Sneezing: ______ Straining: ______ Other (Please List): ___________________, _____

Please Chose the Symptoms that Best Describe Your Pain (circle all that apply):

| Sharp | Dull | Achy | Numbness | Burning | Tingling | Shooting |
|---|---|---|---|---|---|---|
| Deep | Superficial | Sore | Tender | Piercing | Specific | Generalized |

Do you have pain that wakes you up at night: YES / NO If so, is it related to your position: YES / NO

Any changes in bowel or bladder function recently: YES / NO If so, please describe: _________________________

What percent are you limited because of this injury in your normal daily activities (0 – 100%): ________________

What activities are you limited in doing because of this injury: ____________________________________________

Please identify the location(s) of your symptoms (pain, numbness, etc) on the drawing to the right: